# Proposal for Study

# on Productivity of

# Women Doctors

by

Dr. Cynthia Carver

and

Susan Berlin

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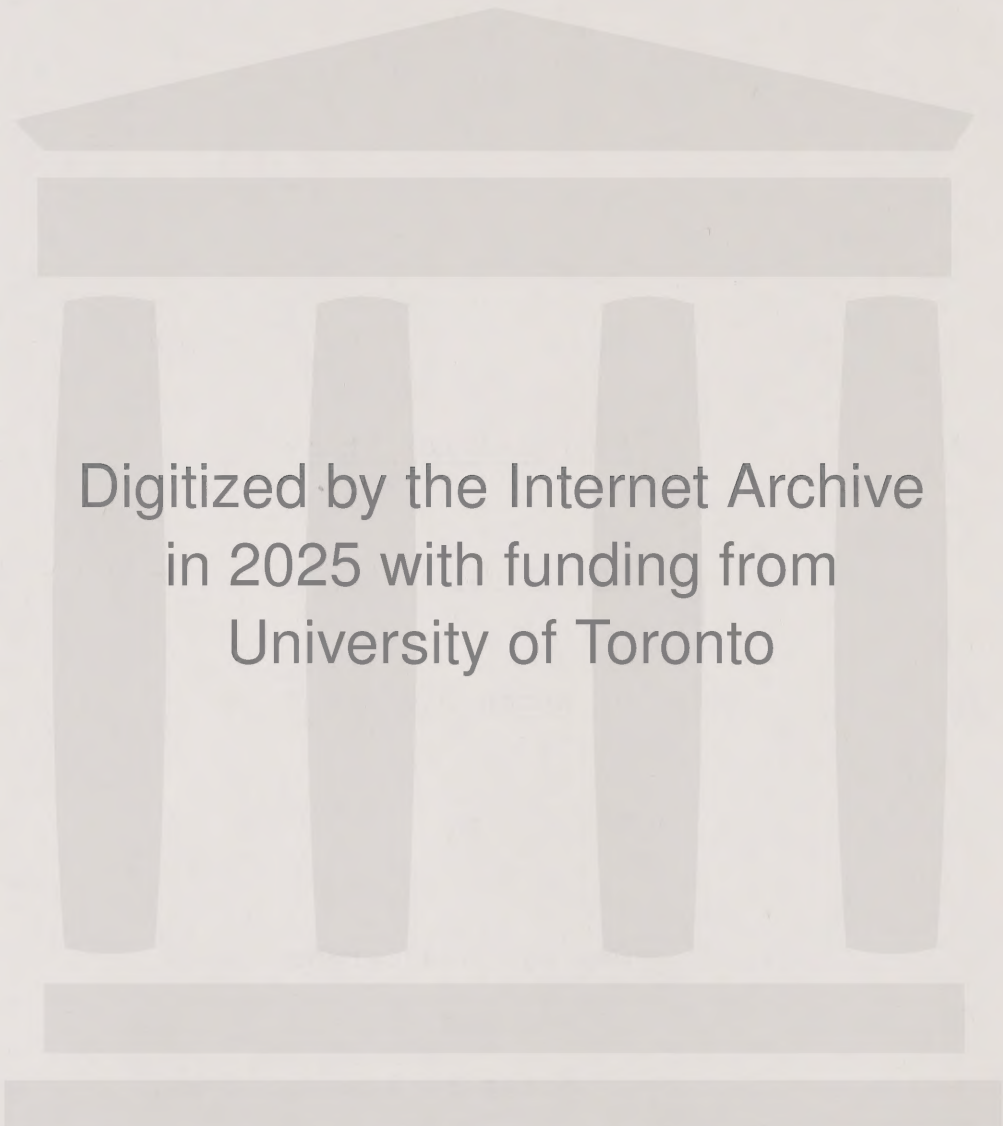

Over the past decade in Canada the number of women admitted to medical school has increased dramatically - from 7 per cent of the entering class to 25 per cent. This year, MacMaster University Medical School will graduate the first class in which over half the entering members were women. Clearly, the barriers preventing women from undertaking medical training are finally down.

It is therefore with some concern that we view comments in a recent submission by the College of Family Practice to the Committee of the Legislature studying Health Care Costs. The College argues that Ontario has barely enough family physicians in practice now, and that within the next decade we will face a shortage of family physician services. According to the College, one of the factors contributing to the shortage is the fact that women make up an increasing proportion of doctors being graduated. The College quotes a Quebec study as showing:

> "...that the productivity of female physicians was 66 per cent of that of the male physician. This was due to the fact that 25 per cent of them do not practise, 25 per cent practise part-time, and 50 per cent maintain full-time practices."

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Although the brief fails to make an exact attribution for these data, it is assumed that they are derived from the January, 1976 Bulletin of the Professional Corporation of Physicians of Quebec, Volume XVI, number 1. If that is so, the quote is inaccurate and taken out of context: the Bulletin indicates that women physicians work an average of 66 per cent of the number of hours worked by male physicians, are paid only 60 per cent that paid their male colleagues, and are 92 per cent as "productive". While there must be serious reservations with regard to the definition of "productivity" used in the Bulletin, its conclusions are nevertheless quite different from those implied by the Family Physicians' submission: "If this analysis is correct, there is no reason to limit the number of female stude in medical schools; on the other hand, in order to av d a waste of skills, the ongoing reform of the health care delivery system should be accelerated, greater value should be placed on certain types of medical practice - such as preventive medicine and geriatrics - which are too often neglected at present, and female physicians who have given up practice should be offered an opportunity to recycle, and be provided with nurseries, in order to enable them to resume an active professional life more easily and more rapidly.

This particular aspect of the College's report received wide publicity, partly because it is one more in a scattered volley of reports recently published which question the productivity of women doctors. It seems likely that in the near future we may have to

face either a movement to increase the number of spaces in medical schools to compensate for the productivity differential; or a movement to reduce the number of women being admitted to medical school; or both. The rationale of such a movement would be economic, not sexist; but the effect would be the same.

It is therefore of great importance that the question of "productivity" among women doctors should be reviewed and assessed now, before any move to limit the enrollment of women is organized. Such a review, however, will permit a meaningful evaluation only if it assesses several special aspects of women's role in medicine: the question of productivity cannot be understood outside the context of the kind of patients women doctors see, the areas of medicine women doctors tend to enter, the ways in which they conduct their practices and the health effects which follow. Some of the questions that must be addressed, for example, are:

1. What is "productivity" and how should it be measured?

2. Are there costs associated with the "productivity pattern" of women doctors?

3. If so, what are these costs - i.e., do they relate to the training of larger numbers of medical students, or to an increased cost in maintaining part-time practices?

4. Are there benefits associated with the productivity pattern of women doctors?

5. If so, what are these benefits?

6. Will changes in medical practice trends generally affect the present differences between practice patterns of male and female doctors?

7. Do women doctors serve any patient needs which male doctors do not?

8. Is the professional/personal situation of women doctors qualitatively different from that of other women professionals? If not, in what way is it more of a problem for the medical care system than it is for any of the other professions?

9. Are there differences in the practice patterns, productivity, etc., among women who entered medicine in each of the decades of this century; and can projections be made of future trends?

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These questions group into five sub-studies, which together would produce a reasonably in-depth picture of the specific ways women contribute to the practice of medicine in Ontario; the problems they have in integrating their professional and personal lives; and the ways in which the profession as a whole can arrange to maximize the degree of service women can provide. The following is a very brief outline of the proposed sub-studies.

I Productivity

A. Definitions of "productivity" used in current studies:

1. number of hours worked/day, month, year.
2. number of patients seen/hour.
3. billings to OHIP.

B. Practice comparisons - male and female physicians:

1. characteristics of work conditions (i.e., private practice, hospital clinic, emergency department, industrial employment).

2. characteristics of patient clientele (age, illness patterns).

C. Attrition rates - male and female physicians lost to family practice:

1. deaths and illness
2. childbearing

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3. changing fields
4. emigration
5. other

D. Corrected productivity: Are women less productive?

II Costs

A. Cost of producing a physician - realistic assessment:
   1. comparison with other professions.
   2. comparison with university education in general.

B. Costs of practice:
   1. increased costs attributable to part-time practice.
   2. referral rates for male and female physicians.
   3. hospitalization rates for patients of each.
   4. repeat visit rates.

C. Are women physicians more expensive practitioners?

III Trends in Family Medicine Practice

A. Practice types:
   1. solo
   2. group
   3. salaried

B. Projections for change.

C. Women physicians and the practice patterns of the coming decades.

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IV Women Physicians' Practice Patterns Over Time

A. Characteristics of women's work and practice patterns, by decade of graduation in medicine.

B. Training and employment opportunities in medicine as they affect women's choice of practice patterns.

C. Projections: trends in women's practice patterns, and how they are likely to compare with men's patterns in future.

V Women in Medicine, Women in Other Professions

A. Work patterns over career lifetime in medicine and several selected professions (some traditionally female; some paid by public funds).

B. Similarities, dissimilarities.

C. Is there a special case, based on economics, for limiting the enrollment of women in medicine?

Summary

It is clear that the basic competency of women to undertake medical training is no longer seriously questioned. Moreover, there seems to be no problem with women who choose to put their energies into a full-time medical career rather than a family, and whose practice patterns are therefore very similar to the male "norm". Increasingly, however - in medicine as in other fields - women have opted to combine professional and family responsibilities. That fact, which

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usually surfaces as at least a temporary part-time practice pattern, offers the opportunity to argue that, quite apart from competency, there are reasons to limit opportunities medicine for women.

A study should be done to evaluate this argument. As a first step, a search of 1) medical registration and employment data; 2) actuarial data; and 3) the literature would permit construction of a more detailed analytic approach to the study.

The costs of such a search, and of the study as a whole, could probably best be estimated after consultation with the Ministry.